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RURAL HEALTH CARE FAIRNESS AND MEDICARE EQUITY ACT

Mr. DORGAN. Mr. President, today I am introducing legislation, the Rural Health Care Fairness and Medicare Equity Act, that will help to make Medicare reimbursement more fair and equitable for rural and small urban hospitals and physicians. I am pleased to be joined in introducing this bill by Senator Burns.

First, let me take a few minutes to describe some of the challenges facing rural health care systems and why I feel it is critical for the Senate to act now to reduce the inequities in Medicare funding between rural and urban providers.

Rural America depends on its small town hospitals, physicians and nurses, nursing homes, emergency ambulance services, and other members of our rural health care system. And because of past cuts in Medicare reimbursement, plus the historical unfairness in Medicare payments, these vital services are in jeopardy. Fortunately, Congress acted in 1999 and again in 2000 to address some of the cuts that turned out to have a larger impact than intended.

However, additional legislation is still needed to improve Medicare reimbursement for health care providers in order to stabilize the Medicare program and ensure that beneficiaries, especially in rural areas, will continue to have access to their local hospitals, physicians, nursing homes, home health, and other services. Many small rural hospitals in particular serve as the anchor for the full range of health care services in their communities, from ambulatory to long-term care. Medicare is the single most significant payer for services at these hospitals, and as such, it has an impact on the whole community.

Part of the problem in North Dakota is simply demographics: North Dakota's population is the fifth oldest in the Nation, and about two-thirds of North Dakota's 103,000 Medicare beneficiaries live in rural areas. In addition, North Dakota's population—and the population of many rural states in our Nation's Heartland—is shrinking daily. In fact, in 13 of North Dakota's counties, there were 20 or fewer births for the entire county in 2001.

Admissions to rural hospitals have dropped by a drastic 60 percent in the last two decades, and those patients who do remain tend to be older, poorer, and sicker. This means that rural hospitals tend to be disproportionately dependent upon Medicare reimbursement, to the extent that Medicare accounts for 75 to 80 percent of the revenue for some rural hospitals. Obviously, given this reality, Medicare reimbursement has a major impact on the financial health of rural hospitals.

Another part of the problem is that Medicare has historically reimbursed urban health care providers at a much higher rate than their rural counterparts. North Dakota Medicare beneficiaries pay the exact same Medicare payroll taxes and premiums as beneficiaries elsewhere but receive less benefit from the Medicare

program. Medicare beneficiaries in North Dakota receive an average of $4,458 in Medicare benefits. This is $632 less than the national average spending per Medicare beneficiary of $5,490, and $5,500 less than the spending for Medicare beneficiaries in Washington, DC. Moreover, most North Dakotans do not even have the option of Medicare+Choice plans because Medicare reimbursement for these plans is so low in rural areas that they are not offered.

As a result of the skewed Medicare formula, North Dakota hospitals are reimbursed significantly less than hospitals of similar size and type elsewhere in the country. For instance, North Dakota hospitals are reimbursed as much as $2,000 less for a Medicare beneficiary with heart failure compared to hospitals of a similar size and mission in Minnesota, New York and California. More specifically, for example, St. Alexius Medical Center in Bismarck, North Dakota is paid about $4,000 for a heart failure patient. A similar sized hospital, with a similar mission, would be paid $5,900 in California, $6,500 in New York, and $6,800 in Minneapolis, MN for caring for the same patient.

Likewise, a similar payment inequity exists for physicians. For example, a physician in Beulah, ND is paid about $46 by Medicare for an office visit, while a doctor in San Francisco is paid $63 for a comparable office visit. A physician who inserts a pacemaker in a patient in New York City is paid about $646, but a doctor who performs the exact same procedure in Fargo, ND is paid only $481, about a quarter less.

This inequity in Medicare reimbursement has real consequences for hospitals and clinics: They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, and struggle to give their patients access to the latest innovations in medical care.

The bill I am introducing today, the Rural Health Care Fairness and Medicare Equity Act, would address the rural inequity in Medicare reimbursement in five ways. First, this bill would equalize the "standardized payment" which forms the basis for Medicare's reimbursement to hospitals. You would think something called the "standardized payment" would already be standard, but the fact is that hospitals in rural and small urban areas, including all of North Dakota, receive a smaller standardized payment than large urban hospitals. This bill would raise all hospitals up to the same standardized payment. The fiscal year 2003 Omnibus Appropriations bill enacted by Congress earlier this year takes a step in the right direction by equalizing this base payment for the last six months of this fiscal year, but my bill would make this equalization permanent.

Second, my bill would create a wage index floor for the hospitals in this country with the very lowest wage indexes. The current wage index, which is an important factor in a hospital's total Medicare reimbursement, is based on an antiquated theory that it costs more to hire hospital staff in urban areas than it does in rural areas. That may have been true once, but it is no longer true today. Today, hospitals in North Dakota are competing with hospitals in Minnesota, Chicago and elsewhere for the same doctors and nurses, and they have to pay competitive wages in order to recruit staff. However, their low wage index has the effect of limiting the salaries that many rural and small urban hospitals can afford to pay their staff. By creating a floor, we would at least level the playing field a bit for hospitals with a wage index under 0.85.

Third, this bill would reduce the importance of the wage index in factoring a hospital's total Medicare reimbursement. The current "labor market share" of 71.1 percent overstates the actual amount that hospitals in North Dakota and nationwide pay for labor. For instance, in North Dakota, a hospital in Bismarck has a labor market share of 58 percent, while a small rural hospital in Cando, ND has a labor market share of 55 percent. For hospitals in North Dakota and other states that already have a low wage index this overstatement of labor costs magnifies the reimbursement inequity. My bill would set the labor market share at 62 percent, which more closely reflects what the correct proportion should be. However, hospitals that would be adversely affected by this change would be held harmless.

In addition, this legislation creates alternative criteria for some hospitals to appeal to the Medicare program for a higher wage index. Hospitals currently can

qualify for reclassification to an area with a higher wage index if they can demonstrate that they are proximate to the area to which they seek to be reclassified and pay similar wages or have a similar patient case-mix. The current reclassification process has been used predominantly in areas with high population density as a way for hospitals to increase their Medicare reimbursement. According to a GAO study last year, two-thirds of all hospitals that are able to reclassify are in two areas—California and the northeast.

Unfortunately, however, many rural and small urban hospitals located in states with a large land base and lots of distance between communities largely have not been able to take advantage of the reclassification process because they cannot meet the proximity criteria. This is the case even though, despite the longer distances between communities, hospitals are still competing against each other to recruit nurses and other staff. To address this concern, my bill would create an alternative reclassification process for hospitals in sparsely populated states with large distances between metropolitan areas that do not meet the current proximity criteria but do meet the other reclassification criteria.

Finally, my legislation would establish a floor of 1.00 for the physician work component of the Medicare physician payment system. The Medicare program currently adjusts physician payments based on a "geographic practice cost index" that is intended to reflect regional cost-of-living differences. The result has been that physicians in rural areas are generally reimbursed less by Medicare for providing the same exact level of care as doctors in urban areas. Since rural medical practices tend to serve higher proportions of Medicare beneficiaries, they are doubly impacted by this payment inequity.

As many of my colleagues know, it is already very difficult to recruit physicians to rural underserved areas. In fact, many small towns in my State are increasingly relying on foreign physicians working in the country under J-1 visas because they are unable to recruit American physicians. I am very concerned that the disparity in Medicare reimbursement for doctors provides yet another reason for physicians to decline to serve in rural areas.

By establishing a floor of 1.00 for the work geographic practice cost index, this legislation will ensure that doctors' work in rural areas would at least be valued at the national average. However, it would still allow for payments higher than the national average for physicians serving in areas with a high cost of living.

In closing, I think we as a nation need to acknowledge that a strong health care system is an important part of our rural infrastructure. Over the years, we have determined that rural electric service, rural telephone service, an interstate highway system through rural areas, and rural mail delivery, to name a few services, make us a better, more unified nation. We need to make the same determination in support of our rural health care system, and I will be fighting for policies, such as those reflected in this legislation, that reflect rural health care as a strong national priority. I encourage my colleagues to join Senator Burns and me in cosponsoring this bill.